EAST GRAND HEALTH CENTER

201 Houlton Rd
Danforth, ME 04424
Phone 207-448-2347
Fax 207-448-2313

No Preference **Dr. Kaplan**
Mary Lake **Lyndsay McIver** **Dayna Lincoln**
Matt Cowan **Tiffany Leach**

Patient information:

Patient's name: _____ DOB: _____

Patient's Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Release Information I authorize East Grand Health Center to:

- ☐ **Give my records to**
- ☐ **Speak with**
- ☐ **Receive my records from**

Name/Facility _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

The purpose of this request:

- ☐ Transferring Care
- ☐ Legal Matters
- ☐ Ongoing Treatment
- ☐ Personal Records
- ☐ Disability Claim
- ☐ Verification of Services
- ☐ Other: _____

***disclaimer: Note to present provider: If this record request is for the purpose of establishing care. This patient will not be accepted to East Grand Health Center until a review has been completed. Your center will remain this patient's provider until further notice, unless patient chose to leave your practice.**

I DO____DO NOT____authorize disclosure of information about **treatment or diagnosis of drug or alcohol abuse.** If I authorize the release of this information, I understand that such information cannot be redisclosed by recipient without my specific consent.
I DO____DO NOT____authorize disclosure of information about **treatment or diagnosis of mental health.**
I DO____DO NOT____authorize disclosure of information which refers to treatment of diagnosis of **HIV** related diseases. I understand that individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, education, life insurance, and social and family relationships.
I DO____DO NOT____want to review information prior to release. (Review must be supervised).

This authorization will expire on_____
Date (Not to exceed 12 months)

I also understand that:

- Future disclosures regarding these records may be to the same individual or entity described until it expires.
- I can revoke all or part of this authorization at any time by notifying the Administrator at EGHC in writing, except for information that may have been disclosed before revocation. I understand that refusal or revocation of permission may result in improper diagnosis or treatment, denial of health benefits or insurance, or other adverse consequences. Revocation will not affect information already given out.
- I can review my medical records or refuse to disclose all or some of the information in them.
- Partial or incomplete records will be labeled as such.
- I can have a copy of this consent form upon request

_____ _____ _____
Signature of Patient Date Witness

_____ _____ _____
Parent, legal guardian, durable Power of Attorney or other authorized representative Date Witness

A patient or guardian is generally required to sign for a patient under the age of 18. Patients aged 14-17 should also sign. If an adult is unable to make or communicate medical decisions, the following may sign the priority given: agent under healthcare power of attorney, guardian, spouse, or next-of-kin. Indicate capacity of representative.